

(ii) Plan services are available 24 hours a day, 7 days a week, when medically necessary.

(9) *Cultural considerations.* Ensure that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.

(10) *Ambulance services, emergency and urgently needed services, and post-stabilization care services coverage.* Provide coverage for ambulance services, emergency and urgently needed services, and post-stabilization care services in accordance with § 422.113.

(b) *Rules for all M+C organizations to ensure continuity of care.* The M+C organization must ensure continuity of care and integration of services through arrangements that include, but are not limited to the following—

(1) Policies that specify under what circumstances services are coordinated and the methods for coordination;

(2) Offering to provide each enrollee with an ongoing source of primary care and providing a primary care source to each enrollee who accepts the offer;

(3) Programs for coordination of plan services with community and social services generally available through contracting or noncontracting providers in the area served by the M+C plan, including nursing home and community-based services; and

(4) Procedures to ensure that the M+C organization and its provider network have the information required for effective and continuous patient care and quality review, including procedures to ensure that—

(i) The M+C organization makes a “best-effort” attempt to conduct an initial assessment of each enrollee’s health care needs, including following up on unsuccessful attempts to contact an enrollee, within 90 days of the effective date of enrollment;

(ii) Each provider, supplier, and practitioner furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the M+C organization, taking into account professional standards; and

(iii) There is appropriate and confidential exchange of information among provider network components.

(5) Procedures to ensure that enrollees are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health; and

(6) Systems to address barriers to enrollee compliance with prescribed treatments or regimens.

[64 FR 7980, Feb. 17, 1999, as amended at 65 FR 40321, June 29, 2000]

§ 422.113 Special rules for ambulance services, emergency and urgently needed services, and maintenance and post-stabilization care services.

(a) *Ambulance services.* The M+C organization is financially responsible for ambulance services, including ambulance services dispatched through 911 or its local equivalent, where other means of transportation would endanger the beneficiary’s health.

(b) *Emergency and urgently needed services.—* (1) *Definitions.*

(i) *Emergency medical condition* means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

(A) Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;

(B) Serious impairment to bodily functions; or

(C) Serious dysfunction of any bodily organ or part.

(ii) *Emergency services* means covered inpatient and outpatient services that are—

(A) Furnished by a provider qualified to furnish emergency services; and

(B) Needed to evaluate or stabilize an emergency medical condition.

(iii) *Urgently needed services* means covered services that are not emergency services as defined this section, provided when an enrollee is temporarily absent from the M+C plan’s service (or, if applicable, continuation)

area (or, under unusual and extraordinary circumstances, provided when the enrollee is in the service or continuation area but the organization's provider network is temporarily unavailable or inaccessible) when the services are medically necessary and immediately required—

(A) As a result of an unforeseen illness, injury, or condition; and

(B) It was not reasonable given the circumstances to obtain the services through the organization offering the M+C plan.

(2) *M+C organization financial responsibility.* The M+C organization is financially responsible for emergency and urgently needed services—

(i) Regardless of whether the services are obtained within or outside the M+C organization;

(ii) Regardless of whether there is prior authorization for the services.

(A) Instructions to seek prior authorization for emergency or urgently needed services may not be included in any materials furnished to enrollees (including wallet card instructions), and enrollees must be informed of their right to call 911.

(B) Instruction to seek prior authorization before the enrollee has been stabilized may not be included in any materials furnished to providers (including contracts with providers);

(iii) In accordance with the prudent layperson definition of *emergency medical condition* regardless of final diagnosis;

(iv) For which a plan provider or other M+C organization representative instructs an enrollee to seek emergency services within or outside the plan; and

(v) With a limit on charges to enrollees for emergency services of \$50 or what it would charge the enrollee if he or she obtained the services through the M+C organization, whichever is less.

(3) *Stabilized condition.* The physician treating the enrollee must decide when the enrollee may be considered stabilized for transfer or discharge, and that decision is binding on the M+C organization.

(c) *Maintenance care and post-stabilization care services* (hereafter to-

gether referred to as “post-stabilization care services”).

(1) *Definition.* *Post-stabilization care services* means covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or, under the circumstances described in paragraph (c)(2)(iii) of this section, to improve or resolve the enrollee's condition.

(2) *M+C organization financial responsibility.* The M+C organization—

(i) Is financially responsible (consistent with § 422.214) for post-stabilization care services obtained within or outside the M+C organization that are pre-approved by a plan provider or other M+C organization representative;

(ii) Is financially responsible for post-stabilization care services obtained within or outside the M+C organization that are not pre-approved by a plan provider or other M+C organization representative, but administered to maintain the enrollee's stabilized condition within 1 hour of a request to the M+C organization for pre-approval of further post-stabilization care services;

(iii) Is financially responsible for post-stabilization care services obtained within or outside the M+C organization that are not pre-approved by a plan provider or other M+C organization representative, but administered to maintain, improve, or resolve the enrollee's stabilized condition if—

(A) The M+C organization does not respond to a request for pre-approval within 1 hour;

(B) The M+C organization cannot be contacted; or

(C) The M+C organization representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, the M+C organization must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in § 422.113(c)(3) is met; and

(iv) Must limit charges to enrollees for post-stabilization care services to an amount no greater than what the organization would charge the enrollee

if he or she had obtained the services through the M+C organization.

(3) *End of M+C organization's financial responsibility.* The M+C organization's financial responsibility for post-stabilization care services it has not pre-approved ends when—

(i) A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;

(ii) A plan physician assumes responsibility for the enrollee's care through transfer;

(iii) An M+C organization representative and the treating physician reach an agreement concerning the enrollee's care; or

(iv) The enrollee is discharged.

[65 FR 40322, June 29, 2000]

§ 422.114 Access to services under an M+C private fee-for-service plan.

(a) *Sufficient access.* (1) An M+C organization that offers an M+C private fee-for-service plan must demonstrate to HCFA that it has sufficient number and range of providers willing to furnish services under the plan.

(2) HCFA finds that an M+C organization meets the requirement in paragraph (a)(1) of this section if, with respect to a particular category of health care providers, the M+C organization has—

(i) Payment rates that are not less than the rates that apply under original Medicare for the provider in question;

(ii) Contracts or agreements with a sufficient number and range of providers to furnish the services covered under the M+C private fee-for-service plan; or

(iii) A combination of paragraphs (a)(2)(i) and (a)(2)(ii) of this section.

(b) *Freedom of choice.* M+C fee-for-service plans must permit enrollees to obtain services from any entity that is authorized to provide services under Medicare Part A and Part B and agrees to provide services under the terms of the plan.

§ 422.118 Confidentiality and accuracy of enrollee records.

For any medical records or other health and enrollment information it maintains with respect to enrollees, an

M+C organization must establish procedures to do the following:

(a) Abide by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. The M+C organization must safeguard the privacy of any information that identifies a particular enrollee and have procedures that specify—

(1) For what purposes the information will be used within the organization; and

(2) To whom and for what purposes it will disclose the information outside the organization.

(b) Ensure that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas.

(c) Maintain the records and information in an accurate and timely manner.

(d) Ensure timely access by enrollees to the records and information that pertain to them.

[65 FR 40323, June 29, 2000]

§ 422.128 Information on advance directives.

(a) Each M+C organization must maintain written policies and procedures that meet the requirements for advance directives, as set forth in subpart I of part 489 of this chapter. For purposes of this part, *advance directive* has the meaning given the term in § 489.100 of this chapter.

(b) An M+C organization must maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the M+C organization.

(1) An M+C organization must provide written information to those individuals with respect to the following:

(i) Their rights under the law of the State in which the organization furnishes services (whether statutory or recognized by the courts of the State) to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. Providers may contract with other entities to furnish this